103D CONGRESS
1ST SESSION

S. 18

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 21 (legislative day, JANUARY 5), 1993

Mr. SPECTER introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Health Care Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—HEALTH CARE INSURANCE REFORM PROVISIONS

Subtitle A—Model Health Care Insurance Benefits Plan

SEC. 101. MODEL HEALTH CARE INSURANCE BENEFITS PLAN.

(a) IN GENERAL.—The Secretary shall request that the NAIC—

(1) develop a model health care insurance benefits plan that shall contain standards that entities offering health care insurance policies should meet with respect to the benefits and coverage provided under such policies, and

(2) report to the Secretary on such standards, not later than 1 year after the date of the enactment of this Act.

If the NAIC develops such a plan by such date and the Secretary finds that such plan implements the requirements of subsection (c), such plan shall be the model health care insurance benefits plan under this Act.

(b) ROLE OF THE SECRETARY IN ABSENCE OF NAIC PLAN.—If the NAIC fails to develop and report a model health care insurance benefits plan by the date specified in subsection (a) or the Secretary finds that such plan does not implement the requirements of subsection (c), the

Secretary shall develop and publish such a plan, by not later than 18 months after the date of the enactment of this Act. Such plan shall then be the plan under this Act.

(c) CONTENTS.—The standards under the model benefits plan should require—

(1) that coverage be provided under health care insurance policies for basic hospital, medical and surgical services, including preventive care services, mental health services, and other ancillary services determined appropriate by the Secretary;

(2) reasonable cost sharing by the beneficiaries under such policies; and

(3) appropriate copayments and deductibles.

SEC. 102. DEFINITIONS.

As used in this title:

(1) HEALTH CARE INSURANCE.—The term ''health care insurance'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, multiple employer welfare arrangement, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1974), or any other health insurance arrangement, and includes an employment-related reinsurance plan, but does not include—

(A) a self-insured health care insurance plan; or

(B) any of the following offered by an insurer—

(i) accident only, dental only, or disability income only insurance,

(ii) coverage issued as a supplement to liability insurance,

(iii) worker's compensation or similar insurance, or

(iv) automobile medical-payment insurance.

(2) MANAGED CARE PLAN.—The term ''managed care plan'' means a health care insurance plan in which the insurer offering such plan utilizes the recommended standards developed under section 111 concerning the benefits and coverage under such plan.

(3) MODEL BENEFITS PLAN.—The term ''model benefits plan'' means the model health care insurance benefits plan developed under section 101(a).

(4) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) SMALL EMPLOYER.—

(A) IN GENERAL.—The term ''small employer'' means any employer which, on an average business day during the preceding taxable year, had more than 2 but less than 100 employees.

(B) EMPLOYEE.—The term ''employee'' shall not include—

(i) a self-employed individual as defined in section 401(c)(1) of the Internal Revenue Code of 1986, or

(ii) an employee who works less than 20 hours per week.

Subtitle B—Managed Care

SEC. 111. DEVELOPMENT OF STANDARDS FOR MANAGED CARE PLANS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary, taking into account recommendations of the Managed Care Advisory Committee, shall develop recommended standards that insurers offering managed care plans should meet with respect to the benefits, coverage, and delivery systems provided under such plans. Such standards shall encompass the standards by which managed care entities operate.

(b) MANAGED CARE ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—There shall be established a Managed Care Advisory Committee (hereinafter referred to as the ''Committee'').

(2) MEMBERSHIP.—The Committee shall be composed of individuals appointed by the Secretary, representing the following:

(A) Consumers.

(B) Physicians.

(C) Nurses.

(D) Hospitals.

(E) Community-based providers.

(F) Organizations delivering managed care services.

(G) Academia (with specific expertise in managed care plans).

(H) Business management.

(I) Organized labor.

(3) COMPENSATION.—

(A) IN GENERAL.—Members of the Committee shall serve without compensation.

(B) EXPENSES, ETC., REIMBURSED.—While away from their homes or regular places of business on the business of the Committee, the members may be allowed travel expenses,

including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons employed intermittently in Government service.

(C) APPLICATION OF ACT.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply with respect to the Committee.

(D) SUPPORT.—The Secretary shall supply such necessary office facilities, office supplies, support services, and related expenses as necessary to carry out the functions of the Committee.

SEC. 112. PREEMPTION OF PROVISIONS RELATING TO MANAGED CARE.

In the case of a managed care plan meeting the recommended standards developed under section 111 that is offered by an insurer, the following provisions of State law are preempted and may not be enforced against the managed care plan with respect to an insurer offering such plan:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of the insurer to negotiate reimbursement rates with health care providers or to

contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that the managed care plan may require a beneficiary to pay when a nonplan provider is used on a nonemergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—

(A) IN GENERAL.—Any law that—

(i) prohibits utilization review of any or all treatments and conditions;

(ii) requires that such review be made by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered;

(iii) requires the use of specified standards of health care practice in such review or requires the disclosure of the specific criteria used in such review;

(iv) requires payments to providers for the expenses of responding to utilization review requests; or

(v) imposes liability for delays in performing such review.

(B) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as prohibiting a State from requiring that utilization review be conducted by a licensed health care professional, or requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(4) RESTRICTIONS ON BENEFITS.—Any law that mandates benefits under the managed care plan that are greater than the benefits recommended under the standards developed under section 111.

Subtitle C—Small Employer Purchasing Groups

SEC. 121. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

(a) DEFINED.—For purposes of this title, an entity is a qualified small employer purchasing group if—

(1) the entity submits an application to the Secretary at such time, in such form and containing such information as the Secretary may require; and

(2) on the basis of information contained in the application and any other information the Secretary may require, the Secretary determines that—

(A) the entity is administered solely under the authority and control of its member employers;

(B) the membership of the entity consists solely of small employers (except that an employer member of the group may retain its membership in the group if, after the Secretary determines that the entity meets the requirements of this subsection, the number of employees of the employer member increases to more than 100);

(C) with respect to each State in which its members are located, the entity consists of not fewer than 100 employers;

(D) at the time the entity submits its application, the health care insurance plans with respect to the employer members of the entity are in compliance with applicable State laws

and the model benefits plan relating to such plans;

(E) the health care insurance plans of the entity and the employer members of the entity are not self-insured plans;

(F) each enrollee in the program of the entity may enroll with any participating carrier that offers health care insurance coverage in the geographic area in which the enrollee resides; and

(G) such entity will be a nonprofit entity; and

(3) such entity has a board of directors as described in subsection (b) with authority to act as described in subsection (c).

(b) OPERATIONS.—A small employer purchasing group shall be administered by a board of directors. The members of such board shall be elected by the employers that are members of the group, and such board members shall serve at the pleasure of the majority of such employers.

(c) DUTIES OF BOARD.—

(1) IN GENERAL.—The board shall have the authority to—

(A) enter into contracts with carriers to provide health care insurance coverage to eligible employees and their dependents;

(B) enter into other contracts as are necessary or proper to carry out the provisions of this subtitle;

(C) employ necessary staff;

(D) appoint committees as necessary to provide technical assistance in the operation of the entity's program;

(E) assess participating employers a reasonable fee for necessary costs in connection with the program;

(F) undertake activities necessary to administer the program including marketing and publicizing the program and assuring carrier, employer, and enrollee compliance with program requirements;

(G) issue rules and regulations necessary to carry out the purpose of this subtitle; and

(H) accept and expend funds received through fees, grants, appropriations, or other appropriate and lawful means.

(2) PROGRAM MANAGEMENT.—

(A) GEOGRAPHIC AREAS OF COVERAGE.—The board shall establish geographic areas within which participating carriers may offer health care insurance coverage to eligible employees and dependents. The board shall contract with sufficient numbers and types of carriers in an area to assure that employees have a choice from among a reasonable number and type of competing health care insurance carriers.

(B) CONTRACT REQUIREMENTS.—

(i) IN GENERAL.—The board shall enter into contracts with qualified carriers for the purpose of providing health care insurance coverage to eligible employees and dependents, and shall pay qualified carriers on at least a monthly basis at the contracted rates.

(ii) GENERAL QUALIFICATIONS OF CARRIERS.—Participating carriers shall be qualified if such carriers have—

(I) adequate administrative management,

(II) financial solvency, and

(III) the ability to assume the risk of providing and paying for covered services.

A participating carrier may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk described in subclause (III). The board may establish risk adjustment mechanisms that can be utilized to address circumstances where a participating carrier has a significantly disproportionate share of high risk or low risk enrollees based upon valid data provided by the carrier. Any such risk adjustment mechanism may be developed and applied only after consultation with the participating carriers.

(C) PROGRAM STANDARDS.—The board shall require that participating carriers that contract with or employ health care providers shall have mechanisms to accomplish at least the following, satisfactory to the program:

(i) Review the quality of care covered.

(ii) Review the appropriateness of care covered.

(iii) Provide accessible health services.

(D) UNIFORMITY OF BENEFITS.—The board shall assure that participating carriers—

(i) shall offer substantially similar benefits to enrollees in the program, except that enrollees cost sharing required by participating carriers may vary according to the basic method of operation of the carrier, and

(ii) shall not vary rates to small employers or enrollees in the program on account of claim experience, health status, or duration from issue.

(E) PAYMENT MECHANISM.—The board shall establish a mechanism to collect premiums from small employers, including remittance of the enrollee's share of the premium.

(3) NOTIFICATION OF PROGRAM BENEFITS.—The board shall use appropriate and efficient means to notify employers of the availability of sponsored health care insurance coverage under the program. The board shall make available marketing materials which accurately summarize the carriers' insurance plans and rates which are offered through the program. A participating carrier may contract with an agent or broker to provide marketing, advertising, or

presentation proposals or otherwise disseminate information regarding coverage or services or rates offered in connection with the program.

(4) CONDITIONS OF PARTICIPATION.—

(A) IN GENERAL.—The board shall establish conditions of participation for small employers and enrollees that—

(i) assure that the entity is a valid small employer purchasing group and is not formed for the purpose of securing health care insurance coverage;

(ii) assure that individuals in the group are not added for the purpose of securing such coverage;

(iii) require that a specified percentage of employees and dependents obtain health care insurance coverage;

(iv) require minimum employer contributions; and

(v) require prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

(B) MINIMUM PARTICIPATION.—The board may require participating employers to agree to participate in the program for a specified mini-

mum period of time and may include in any participation agreements with employers a requirement for a financial deposit or provision for a financial penalty, which would be invoked in the event the employer violates the participation agreement.

(d) GRANTS.—

(1) AUTHORITY.—The Secretary may award grants to qualified small employer purchasing groups to assist such groups in paying the expenditures associated with the formation and initial operations of such groups.

(2) APPLICATION.—To be eligible to receive a grant under this subsection, a qualified small employer purchasing group shall request such a grant as part of the application submitted by such group under subsection (a)(1).

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for awarding grants under this subsection such sums as may be necessary.

(e) FREEDOM OF CONTRACT.—Nothing in this subtitle shall be construed to prohibit a participating carrier from offering health care insurance coverage to small em-

ployers that are not participating in the program of a small employer purchasing group.

SEC. 122. PREEMPTION FROM INSURANCE MANDATES FOR SMALL EMPLOYER PURCHASING GROUPS.

(a) FINDING.—The Congress finds that qualified small employer purchasing groups organized for the purpose of obtaining health insurance for the employer members of such groups affect interstate commerce.

(b) PREEMPTION OF STATE MANDATES.—In the case of a qualified small employer purchasing group, no provision of State law shall apply that requires the offering, as part of the health care insurance plan with respect to an employer member of such a group, of any services, category of care, or services of any class or type of provider that is in excess of that recommended under the model benefit plan.

Subtitle D—Insurance Market Reform

SEC. 131. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH CARE INSURANCE PROVIDED TO SMALL EMPLOYERS.

(a) IN GENERAL.—Subchapter L of chapter 1 of the Internal Revenue Code of 1986 (relating to insurance companies) is amended by adding at the end thereof the following new part:

"PART IV—HEALTH CARE INSURANCE PROVIDED TO SMALL EMPLOYERS

"SEC. 850. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH CARE INSURANCE OF SMALL EMPLOYERS.

''(a) GENERAL RULE.—No health insurance contract issued to an eligible small employer shall be treated as a contract for purposes of section 807 or 832 if the issuer of such a contract fails to meet at any time during any taxable year—

''(1) the general issuance requirements of section 850A, or

''(2) the specific contractual requirements of section 850B.

''(b) LIMITATION.—

''(1) SECTION NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—Subsection (a) shall not apply with respect to any failure for which it is established to the satisfaction of the Secretary that the person described in such subsection did not know, or exercising reason-

able diligence would not have known, that such failure existed.

''(2) SECTION NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—Subsection (a) shall not apply with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons described in such subsection knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive the application of subsection (a).

"SEC. 850A. GENERAL ISSUANCE REQUIREMENTS.

''(a) GENERAL RULE.—The requirements of this section are met if a person meets—

''(1) the mandatory policy requirements of subsection (b),

''(2) the guaranteed issue requirements of subsection (c), and

''(3) the mandatory registration and disclosure requirements of subsection (d).

''(b) MANDATORY POLICY REQUIREMENTS.—

''(1) IN GENERAL.—The requirements of this subsection are met if any person issuing a health care insurance contract to any eligible small employer makes available to such employer a health care insurance contract which—

''(A) provides benefits and coverage consistent with the model health care insurance benefits plan developed under section 101 of the Comprehensive Health Care Act of 1993, and

''(B) is for a term of not less than 12 months.

''(2) PRICING AND MARKETING REQUIREMENTS.—The requirements of paragraph (1) are not met unless—

''(A) the price at which the contract described in paragraph (1) is made available is not greater than the price for such contract determined on the same basis as prices for other health care insurance contracts within the same class of business made available by the person to eligible small employers, and

''(B) such contract is made available to eligible small employers using at least the market-

ing methods and other sales practices which are used in selling such other contracts.

''(c) GUARANTEED ISSUE.—

''(1) IN GENERAL.—The requirements of this subsection are met if the person offering health care insurance contracts to eligible small employers issues such a contract to any eligible small employer seeking to enter into such a contract.

''(2) FINANCIAL CAPACITY EXCEPTION.—Paragraph (1) shall not require any person to issue a health care insurance contract to the extent that the issuance of such contract would result in such person violating the financial solvency standards (if any) established by the State in which such contract is to be issued.

''(3) DELIVERY CAPACITY EXCEPTION.—Paragraph (1) shall not require any person to issue a health care insurance contract to the extent that the issuance of such contract would result, upon demonstration to the Secretary, in such person exceeding such person's administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups).

''(4) EXCEPTION FOR CERTAIN EMPLOYERS.—Paragraph (1) shall not apply to a failure to issue a health care insurance contract to an eligible small employer if—

''(A) such employer is unable to pay the premium for such contract, or

''(B) in the case of an eligible small employer with fewer than 15 employees, such employer fails to enroll a minimum percentage of the employer's eligible employees for coverage under such contract, so long as such percentage is enforced uniformly for all eligible small employers of comparable size.

''(5) EXCEPTION FOR ALTERNATIVE STATE PROGRAMS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply if the State in which the health care insurance contract is issued—

''(i) has a program which—

''(I) assures the availability of health care insurance contracts to eligible small employers through the equitable distribution of high risk groups among all persons offering such contracts to such employers, and

''(II) is consistent with a model program developed by the NAIC;

''(ii) has a qualified State-run reinsurance program, or

''(iii) has a program which the Secretary of Health and Human Services has determined assures all eligible small employers in the State an opportunity to purchase a health care insurance contract without regard to any risk characteristic.

''(B) REINSURANCE PROGRAM.—

''(i) PROGRAM REQUIREMENTS.—For purposes of subparagraph (A)(ii), a State-run reinsurance program is qualified if such program is one of the NAIC reinsurance program models developed under clause (ii) or is a variation of one of such models, as approved by the Secretary of Health and Human Services.

''(ii) MODELS.—Not later than 120 days after the date of the enactment of the Comprehensive Health Care Act of 1993, the NAIC shall develop several models for a reinsurance program, including options for program funding.

''(d) MANDATORY REGISTRATION AND DISCLOSURE REQUIREMENTS.—The requirements of this subsection are met if the person offering health care insurance contracts to eligible small employers in any State—

''(1) registers with the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance,

''(2) fully discloses the rating practices for small employer health care insurance contracts at the time such person offers a health care insurance contract to an eligible small employer, and

''(3) fully discloses the terms for renewal of the contract at the time of the offering of such contract and at least 90 days before the expiration of such contract.

"SEC. 850B. SPECIFIC CONTRACTUAL REQUIREMENTS.

''(a) GENERAL RULE.—The requirements of this section are met if the following requirements are met:

''(1) The coverage requirements of subsection (b).

''(2) The rating requirements of subsection (c).

''(b) COVERAGE REQUIREMENTS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any health care

insurance contract if, under the terms and operation of the contract, the following requirements are met:

''(A) GUARANTEED ELIGIBILITY.—No eligible employee (and the spouse or any dependent child of the employee eligible for coverage) may be excluded from coverage under the contract.

''(B) LIMITATIONS ON COVERAGE OF PREEXISTING CONDITIONS.—Any limitation under the contract on any preexisting condition—

''(i) may not extend beyond the 6-month period beginning with the date an insured is first covered by the contract, and

''(ii) may only apply to preexisting conditions which manifested themselves, or for which medical care or advice was sought or recommended, during the 3-month period preceding the date an insured is first covered by the contract.

''(C) GUARANTEED RENEWABILITY.—

''(i) IN GENERAL.—The contract must be renewed at the election of the eligible small employer unless the contract is terminated for cause.

''(ii) CAUSE.—For purposes of this subparagraph, the term 'cause' means—

''(I) nonpayment of the required premiums;

''(II) fraud or misrepresentation of the employer or, with respect to coverage of individual insureds, the insureds or their representatives;

''(III) noncompliance with the contract's minimum participation requirements;

''(IV) noncompliance with the contract's employer contribution requirements; or

''(V) repeated misuse of a provider network provision in the contract.

''(2) WAITING PERIODS.—Paragraph (1)(A) shall not apply to any period an employee is excluded from coverage under the contract solely by reason of a requirement applicable to all employees that a minimum period of service with the employer is required before the employee is eligible for such coverage.

''(3) DETERMINATION OF PERIODS FOR RULES RELATING TO PREEXISTING CONDITIONS.—For purposes of paragraph (1)(B), the date on which an insured is first covered by a contract shall be the earlier of—

''(A) the date on which coverage under such contract begins, or

''(B) the first day of any continuous period—

''(i) during which the insured was covered under one or more other health insurance arrangements, and

''(ii) which does not end more than 120 days before the date employment with the employer begins.

''(4) CESSATION OF SMALL EMPLOYER HEALTH INSURANCE BUSINESS.—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, a person shall not be treated as failing to meet the requirements of paragraph (1)(C) if such person terminates the class of business which includes the health care insurance contract.

''(B) NOTICE REQUIREMENT.—Subparagraph (A) shall apply only if the person gives

notice of the decision to terminate at least 90 days before the expiration of the contract.

''(C) 5-YEAR MORATORIUM.—If, within 5 years of the year in which a person terminates a class of business under subparagraph (A), such person establishes a new class of business, the issuance of such contracts in that year shall be treated as a failure to which this section applies.

''(D) TRANSFERS.—If, upon a failure to renew a contract to which subparagraph (A) applies, a person offers to transfer such contract to another class of business, such transfer must be made without regard to risk characteristics.

''(c) RATING REQUIREMENTS.—

''(1) IN GENERAL.—The requirements of this subsection are met if—

''(A) the requirements of paragraphs (2) and (3) are met, and

''(B) any increase in any premium rate under the renewal contract over the corresponding rate under the health care insurance contract being renewed does not exceed the applicable annual adjusted increase.

''(2) LIMIT ON VARIATION OF PREMIUMS BETWEEN CLASSES OF BUSINESS.—

''(A) IN GENERAL.—The requirements of this paragraph are met if the index rate for a rating period for any class of business of the insurer does not exceed the index rate for any other class of business by more than 20 percent.

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply to a class of business if—

''(i) the class is one for which the insurer does not reject, and never has rejected, eligible small employers included within the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon risk characteristics,

''(ii) the insurer does not transfer, and never has transferred, a health care insurance contract involuntarily into or out of the class of business, and

''(iii) the class of business is currently available for purchase.

''(3) LIMIT ON VARIATION IN PREMIUM RATES WITHIN A CLASS OF BUSINESS.—The requirements

of this paragraph are met if the premium rates charged during a rating period to eligible small employers with similar case characteristics (other than risk characteristics) for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, do not vary from the index rate by more than 20 percent of the index rate.

''(4) APPLICABLE ANNUAL ADJUSTED INCREASE.—For purposes of paragraph (1)(B)—

''(A) IN GENERAL.—The applicable annual adjusted increase is an amount equal to the sum of—

''(i) the applicable percentage of the premium rate under the health care insurance contract being renewed, plus

''(ii) any increase in the rate under the renewal contract due to any change in coverage or to any change of case characteristics (other than risk characteristics), plus

''(iii) 5 percentage points.

''(B) APPLICABLE PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the applicable percentage is the percentage (if any) by which—

''(I) the premium rate for newly issued contracts for substantially similar coverage for an employer with similar case characteristics (other than risk characteristics) as the employer under the health care insurance contract (determined on the 1st day of the rating period applicable to such contracts), exceeds

''(II) such rate on the 1st day of the rating period applicable to the contract being renewed.

''(ii) CASES WHERE NO NEW BUSINESS.—If no new contracts are being issued for a class of business during any rating period, the applicable percentage shall be the percentage (if any) by which the base premium rate determined under paragraph (5)(B) with respect to the renewal contract exceeds such rate for the contract to be renewed.

''(5) DEFINITIONS.—For purposes of this subsection—

''(A) INDEX RATE.—The term 'index rate' means, with respect to a class of business, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate for that class.

''(B) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business for each rating period, the lowest premium rate which could have been charged under a rating system for that class of business by the insurer to eligible small employers with similar case characteristics (other than risk characteristics) for health care insurance contracts with the same or similar coverage.

"SEC. 850C. STATE COMPLIANCE AGREEMENTS.

''(a) AGREEMENTS.—The Secretary of Health and Human Services may enter into an agreement with any State—

''(1) to apply the standards set by the NAIC for health care insurance contracts in lieu of the requirements of this subchapter, and

''(2) to provide for the State to make the initial determination as to whether a person is in compli-

ance with such standards for purposes of applying the sanctions under section 850.

''(b) STANDARDS.—An agreement may be entered into under subsection (a)(1) only if—

''(1) the chief executive officer of the State requests that such agreement be entered into,

''(2) the Secretary of Health and Human Services determines that the NAIC standards to be applied under the agreement will carry out the purposes of this subchapter, and

''(3) the Secretary determines that the NAIC standards to be applied under the agreement will apply to substantially all health care insurance contracts issued in such State to eligible small employers.

''(c) TERMINATION.—The Secretary of Health and Human Services shall terminate any agreement if the Secretary determines that the application of NAIC standards by the State ceases to carry out the purposes of this subchapter.

''(d) NAIC STANDARDS.—Not later than 270 days after the date of the enactment of the Comprehensive Health Care Act of 1993, the NAIC shall develop standards which provide for requirements substantially similar to the requirements of this subchapter.

"SEC. 850D. DEFINITIONS AND OTHER RULES.

''For purposes of this part—

''(1) HEALTH CARE INSURANCE.—The term 'health care insurance' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, multiple employer welfare arrangement, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1974), or any other health insurance arrangement, and includes an employment-related reinsurance plan, but does not include—

''(A) a self-insured health care insurance plan; or

''(B) any of the following offered by an insurer—

''(i) accident only, dental only, or disability income only insurance,

''(ii) coverage issued as a supplement to liability insurance,

''(iii) worker's compensation or similar insurance, or

''(iv) automobile medical-payment insurance.

''(2) CLASS OF BUSINESS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'class of business' means, with respect to health care insurance provided to eligible small employers, all health care insurance provided to such employers.

''(B) ESTABLISHMENT OF GROUPINGS.—

''(i) IN GENERAL.—An issuer may establish separate classes of business with respect to health care insurance provided to eligible small employers but only if such classes are based on one or more of the following:

''(I) Business marketed and sold through persons not participating in the marketing and sale of such insurance to other eligible small employers.

''(II) Business acquired from other insurers as a distinct grouping.

''(III) Business provided through an association of not less than 20 eligible small employers which was established for purposes other than obtaining insurance.

''(IV) Business related to managed care plans (as defined in section

102(2) of the Comprehensive Health Care Act of 1993.

''(V) Any other business which the Secretary of Health and Human Services determines needs to be separately grouped to prevent a substantial threat to the solvency of the insurer.

''(ii) EXCEPTION ALLOWED.—Except as provided in subparagraph (C), an insurer may not establish more than one distinct group of eligible small employers for each category specified in clause (i).

''(C) SPECIAL RULE.—An insurer may establish up to 2 groups under each category in subparagraph (A) or (B) to account for differences in characteristics (other than differences in plan benefits) of health insurance plans that are expected to produce substantial variation in health care costs.

''(3) CHARACTERISTICS.—

''(A) IN GENERAL.—The term 'characteristics' means, with respect to any insurance rating system, the factors used in determining rates.

''(B) RISK CHARACTERISTICS.—The term 'risk characteristics' means factors related to the health risks of individuals, including health status, prior claims experience, the duration since the date of issue of a health insurance plan or arrangement, industry, and occupation.

''(C) GEOGRAPHIC FACTORS.—

''(i) IN GENERAL.—In applying geographic location as a characteristic, an insurer may not use for purposes of this subchapter areas smaller than 3-digit postal zip code areas.

''(ii) STUDY AND REPORT.—Not later than 120 days after the date of the enactment of the Comprehensive Health Care Act of 1993, the Comptroller General of the United States shall study and report to the Congress concerning—

''(I) insurance industry practices in determining the geographic boundaries of communities used for setting rates,

''(II) the feasibility and desirability of establishing standardized geo-

graphic communities for setting rates, and

''(III) the effect such standardized geographic communities would have on rates charged small employers.

''(4) ELIGIBLE SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'eligible small employer' means any person which, on an average business day during the preceding taxable year, had more than 2 but less than 50 employees.

''(B) AGGREGATION RULES.—All members of the same controlled group of corporations (within the meaning of section 52(a)) and all persons under common control (within the meaning of section 52(b)) shall be treated as 1 person.

''(C) EMPLOYEE.—The term 'employee' shall not include—

''(i) a self-employed individual as defined in section 401(c)(1), or

''(ii) an employee who works less than 20 hours per week.

''(5) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.''.

(b) CONFORMING AMENDMENT.—Subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

''Part IV. Health Care Insurance Provided to Small Employers.''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued, or renewed, after the date of the enactment of this Act.

(2) GUARANTEED ISSUE.—The provisions of section 850A(c) of the Internal Revenue Code of 1986, as added by this section, shall apply to contracts which are issued, or renewed, after the date which is 18 months after the date of the enactment of this Act.

(3) PREMIUM RANGE.—In the case of any contract in effect on the date of the enactment of this Act, the provisions of section 850B(c)(1)(A) of such Code, as added by this section, shall not apply to the premiums under such contract or any renewal contract for benefits provided during the period beginning on such date and ending on the last day of the 2nd plan year beginning after such date.

Subtitle E—Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 141. INCREASE IN DEDUCTIBLE HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''25 percent'' and inserting ''100 percent''.

(b) REPEAL OF TERMINATION PROVISION.—Paragraph (6) of section 162(l) of such Code (relating to termination) is repealed.

(c) CONFORMING AMENDMENT.—Section 110(a) of the Tax Extension Act of 1991 is amended by striking paragraph (2).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after June 30, 1992.

TITLE II—PRIMARY AND PREVENTIVE CARE SERVICES

SEC. 201. MATERNAL AND INFANT CARE COORDINATION.

(a) PURPOSE.—It is the purpose of this section to assist States in the development and implementation of coordinated, multidisciplinary, and comprehensive primary

health care and social services, and health and nutrition education programs, designed to improve maternal and child health.

(b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

(1) AUTHORITY.—The Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'') is authorized to award grants to States to enable such States to plan and implement coordinated, multidisciplinary, and comprehensive primary health care and social service programs targeted to pregnant women and infants.

(2) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

(A) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(B) provide assurances that under the program established with amounts received under a grant, individuals will have access (without any barriers) to comprehensive family planning counseling, pregnancy testing, prenatal care, delivery, intrapartum and postpartum care, pediatric care for infants, and social services as appropriate, including outreach activities, home

visits, child care, transportation, risk assessment, nutrition counseling, dental care, mental health services, substance abuse services, services relating to HIV infection, and prevention counseling;

(C) provide assurances that under the program individuals will have access, without any barriers, to the full range of pediatric services provided by pediatric nurse practitioners and clinical nurse specialists, including in-home services for low birth weight babies;

(D) as part of the State application, submit a plan for providing incentive payments of up to $500 to pregnant women who—

(i) have not attained age 20;

(ii) are at risk of having low birth weight babies;

(iii) agree to attend not less than 5 prenatal visits and 1 postnatal visit; and

(iv) agree to attend a requisite number of prenatal care and parenting classes, as determined by the State;

(E) as part of the State application, submit a plan for the coordination and maximization of existing and proposed Federal and State

resources, including amounts provided under the medicaid program under title XIX of the Social Security Act, the special supplemental food program under section 17 of the Child Nutrition Act of 1966, family planning programs, substance abuse programs, State maternal and child health programs funded under title V of the Social Security Act, community and migrant health center programs under the Public Health Service Act, and other publicly, or where practicable, privately supported programs;

(F) demonstrate that the major service providers to be involved, including private nonprofit entities committed to improving maternal and infant health, are committed to and involved in the program to be funded with amounts received under the grant;

(G) with respect to States with high infant mortality rates among minority populations, demonstrate the involvement of major health, multiservice, professional, or civic group representatives of such minority groups in the planning and implementation of the State program; and

(H) demonstrate that health promotion and outreach activities under the State program are targeted to women of childbearing age, particularly those at risk for having low birth weight babies.

(3) TERM OF GRANT.—A grant awarded under this subsection shall be for a period of 5 years.

(4) USE OF AMOUNTS.—Amounts received by a State under a grant awarded under this subsection shall be used to establish a State program to provide coordinated, multidisciplinary, and comprehensive primary health care and social services, and health and nutrition education program services, that are designed to improve maternal and child health.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for fiscal year 1994, $300,000,000 for fiscal year 1995, and $500,000,000 for each of the fiscal years 1996 through 1998.

(c) MODEL HEALTH AND NUTRITION EDUCATION CURRICULA.—

(1) AUTHORITY.—The Secretary, in conjunction with the Secretary of Education and the Secretary of Agriculture, is authorized to award grants, on a

competitive basis, to public or nonprofit private entities to enable such entities to develop model health and nutrition education curricula for children in grades kindergarten through twelfth.

(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) CURRICULA.—Curricula developed under paragraph (1) should be consistent with the goals of ''Healthy People 2000: National Health Promotion and Disease Prevention Objectives'', published by the Department of Health and Human Services in September 1990, and shall address the cultural and lifestyle realities of racial and ethnic minority populations.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $10,000,000 for fiscal year 1994.

SEC. 202. REAUTHORIZATION OF CERTAIN PROGRAMS PROVIDING PRIMARY AND PREVENTIVE CARE.

(a) IMMUNIZATION PROGRAMS.—Section 317(j)(1)(A) of the Public Health Service Act (42 U.S.C. 247b(j)(1)(A)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''each of the fiscal years 1992 through 1995'' and inserting ''each of the fiscal years 1992 and 1993, $380,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(b) TUBERCULOSIS PREVENTION GRANTS.—Section 317(j)(2) of the Public Health Service Act (42 U.S.C. 247b(j)(2)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''each of the fiscal years 1992 through 1995'' and inserting ''each of the fiscal years 1992 and 1993, $30,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(c) SEXUALLY TRANSMITTED DISEASES.—Section 318(d)(1) of the Public Health Service Act (42 U.S.C. 247c(d)(1)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by inserting before the first period the following: ''$125,000,000 for fiscal year 1994, and

such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(d) MIGRANT HEALTH CENTERS.—Section 329(h)(1)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(1)(A)) is amended by striking ''and 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994'' and inserting ''through 1993, $80,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(e) COMMUNITY HEALTH CENTERS.—Section 330(g)(1)(A) of the Public Health Service Act (42 U.S.C. 254c(g)(1)(A)) is amended by striking ''and 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994'' and inserting ''through 1993, $700,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(f) HEALTH CARE SERVICES FOR THE HOMELESS.—Section 340(q)(1) of the Public Health Service Act (42 U.S.C. 256(q)(1)) is amended by striking ''and such sums'' and all that follows through the period and inserting ''$90,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998.''.

(g) FAMILY PLANNING PROJECT GRANTS.—Section 1001(d) of the Public Health Service Act (42 U.S.C. 300(d)) is amended—

(1) by striking ''and $158,400,000'' and inserting ''$158,400,000''; and

(2) by inserting before the period the following: '', $200,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(h) BREAST AND CERVICAL CANCER PREVENTION.—Section 1509(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''for each of the fiscal years 1992 and 1993'' and inserting ''for each of the fiscal years 1992 and 1993, $100,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(i) PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT.—Section 1901(a) of the Public Health Service Act (42 U.S.C. 300w(a)) is amended by striking ''$205,000,000'' and inserting ''$235,000,000''.

(j) HIV EARLY INTERVENTION.—Section 2655 of the Public Health Service Act (42 U.S.C. 300ff–55) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''each of the fiscal years 1992 through 1995'' and inserting ''each of fiscal years 1992 and 1993, $310,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998''.

(k) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.—Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by striking ''$686,000,000 for fiscal year 1990 and each fiscal year thereafter'' and inserting ''$800,000,000 for fiscal year 1994, and such sums as may be necessary in each of the fiscal years 1995 through 1998''.

SEC. 203. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.

Section 4605 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 3155) is amended to read as follows:

"SEC. 4605. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

''(a) PURPOSE.—It is the purpose of this section to establish a comprehensive school health education and prevention program for elementary and secondary school students.

''(b) PROGRAM AUTHORIZED.—The Secretary, through the Office of Comprehensive School Health Education established in subsection (e), shall award grants to States from allotments under subsection (c) to enable such States to—

''(1) award grants to local or intermediate educational agencies, and consortia thereof, to enable such agencies or consortia to establish, operate and improve local programs of comprehensive health education and prevention, early health intervention, and health education, in elementary and secondary schools (including preschool, kindergarten, intermediate, and junior high schools); and

''(2) develop training, technical assistance and coordination activities for the programs assisted pursuant to paragraph (1).

''(c) RESERVATIONS AND STATE ALLOTMENTS.—

''(1) RESERVATIONS.—From the sums appropriated pursuant to the authority of subsection (f) for any fiscal year, the Secretary shall reserve—

''(A) 1 percent for payments to Guam, American Samoa, the Virgin Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, the Northern Mariana Islands, and the Republic of Palau, to be allotted in accordance with their respective needs; and

''(B) 1 percent for payments to the Bureau of Indian Affairs.

''(2) STATE ALLOTMENTS.—From the remainder of the sums not reserved under paragraph (1), the Secretary shall allot to each State an amount which bears the same ratio to the amount of such remainder as the school-age population of the State bears to the school-age population of all States, except that no State shall be allotted less than an amount equal to 0.5 percent of such remainder.

''(3) REALLOTMENT.—The Secretary may reallot any amount of any allotment to a State to the extent that the Secretary determines that the State will not be able to obligate such amount within 2 years of allotment. Any such reallotment shall be made on the same basis as an allotment under paragraph (2).

''(d) USE OF FUNDS.—Grant funds provided to local or intermediate educational agencies, or consortia thereof,

under this section may be used to improve elementary and secondary education in the areas of—

''(1) personal health and fitness;

''(2) prevention of chronic diseases;

''(3) prevention and control of communicable diseases;

''(4) nutrition;

''(5) substance use and abuse;

''(6) accident prevention and safety;

''(7) community and environmental health;

''(8) mental and emotional health;

''(9) parenting and the challenges of raising children; and

''(10) the effective use of the health services delivery system.

''(e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The Secretary shall establish within the Office of the Secretary an Office of Comprehensive School Health Education which shall have the following responsibilities:

''(1) To recommend mechanisms for the coordination of school health education programs conducted by the various departments and agencies of the Federal Government.

''(2) To advise the Secretary on formulation of school health education policy within the Department of Education.

''(3) To disseminate information on the benefits to health education of utilizing a comprehensive health curriculum in schools.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated $50,000,000 for fiscal year 1994 and such sums as may be necessary for each of the fiscal years 1995 and 1996 to carry out this section.

''(2) AVAILABILITY.—Funds appropriated pursuant to the authority of paragraph (1) in any fiscal year shall remain available for obligation and expenditure until the end of the fiscal year succeeding the fiscal year for which such funds were appropriated.''.

SEC. 204. COMPREHENSIVE EARLY CHILDHOOD HEALTH EDUCATION PROGRAM.

(a) PURPOSE.—It is the purpose of this section to establish a comprehensive early childhood health education program.

(b) PROGRAM.—The Secretary of Health and Human Services shall conduct a program of awarding grants to agencies conducting Head Start training to enable such

agencies to provide training and technical assistance to Head Start teachers and other child care providers. Such program shall—

(1) establish a training system through the Head Start agencies and organizations conducting Head Start training for the purpose of enhancing teacher skills and providing comprehensive early childhood health education curriculum;

(2) enable such agencies and organizations to provide training to day care providers in order to strengthen the skills of the early childhood workforce in providing health education;

(3) provide technical support for health education programs and curricula; and

(4) provide cooperation with other early childhood providers to ensure coordination of such programs and the transition of students into the public school environment.

(c) USE OF FUNDS.—Grant funds under this section may be used to provide training and technical assistance in the areas of—

(1) personal health and fitness;

(2) prevention of chronic diseases;

(3) prevention and control of communicable diseases;

(4) dental health;

(5) nutrition;

(6) substance use and abuse;

(7) accident prevention and safety;

(8) community and environmental health;

(9) mental and emotional health; and

(10) strengthening the role of parent involvement.

(d) RESERVATION FOR INNOVATIVE PROGRAMS.—The Secretary shall reserve 5 percent of the funds appropriated pursuant to the authority of subsection (e) in each fiscal year for the development of innovative model health education programs or curricula.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $40,000,000 for fiscal year 1994 and such sums as may be necessary for each of the fiscal years 1995 and 1996 to carry out this section.

TITLE III—DISCLOSURE OF CERTAIN INFORMATION TO BENEFICIARIES UNDER THE MEDICARE AND MEDICAID PROGRAMS

SEC. 301. REGULATIONS REQUIRING DISCLOSURE OF CERTAIN INFORMATION TO BENEFICIARIES UNDER THE MEDICARE AND MEDICAID PROGRAMS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

''DISCLOSURE OF CERTAIN INFORMATION TO BENEFICIARIES UNDER THE MEDICARE AND MEDICAID PROGRAMS

''SEC. 1144. (a) ANNUAL REPORTS.—

''(1) INSTITUTIONAL HEALTH CARE PROVIDERS.—

''(A) IN GENERAL.—The Secretary shall issue regulations requiring that each institutional health care provider receiving payment for services provided under title XVIII or XIX shall make an annual report available to the recipients of services under such title.

''(B) CONTENTS OF REPORT.—The annual report referred to in subparagraph (A) shall include—

''(i) mortality rates relating to services provided to individuals, including incidence and outcomes of surgical and other invasive procedures;

''(ii) nosocomial infection rates;

''(iii) a list of routine preoperative tests and other frequently performed medical tests, including blood tests, chest x-rays, magnetic resonance imaging, computerized axial tomography, urinalysis, and heart catherizations, and the cost of such tests;

''(iv) the number and types of malpractice claims against the provider decided or settled for the year; and

''(v) such other information as the Secretary shall require.

''(2) NONINSTITUTIONAL HEALTH CARE PROVIDERS.—

''(A) IN GENERAL.—The Secretary shall issue regulations requiring that each noninstitutional provider receiving payment for

services provided under title XVIII or XIX shall make an annual report available to the recipients of services under such title.

''(B) CONTENTS OF REPORT.—The report referred to in subparagraph (A) shall include—

''(i) information regarding the provider's education, experience, qualifications, board certification, and license to provide health care services, including a list of the States in which such provider is licensed and any limitations on such provider's license;

''(ii) any disciplinary actions taken against the provider by any health care facility, State medical agency, or medical organization which result in a finding of improper conduct;

''(iii) any malpractice action against the provider decided or settled;

''(iv) a disclosure of any ownership interest the provider may have in any health care facility, laboratory, or health care supply company; and

''(v) such other information as the Secretary shall require.

''(b) DISCLOSURE OF INFORMATION REGARDING HEALTH CARE PROCEDURES AND FORMS.—

''(1) INFORMATION REGARDING HEALTH CARE PROCEDURES AND FORMS.—The Secretary shall issue regulations requiring that each institutional and noninstitutional health care provider receiving payment for services under title XVIII or XIX shall make available any forms required in connection with the receipt of services under such title which consist of any diagnostic, surgical, or other invasive procedure, prior to the performance of such procedure.

''(2) INFORMATION PROVIDED BEFORE PERFORMANCE OF PROCEDURE.—The Secretary shall issue regulations requiring each institutional and noninstitutional health care provider receiving payment for services provided under title XVIII or XIX to disclose to any individual receiving any surgical, palliative, or other health care procedure or any drug therapy or other treatment, the following information prior to the performance of such procedure or treatment:

''(A) The nature of the procedure or treatment.

''(B) A description of the procedure or treatment.

''(C) The risk and benefits associated with the procedure or treatment.

''(D) The success rate for the procedure or treatment generally, and for the provider.

''(E) The provider's cost range for the procedure or treatment.

''(F) Any alternative treatment which may be available to such individual.

''(G) Any known side effects of any medications required in connection with the procedure or treatment.

''(H) The interactive effect of the complete regimen of medications associated with the procedure.

''(I) The availability of the information under this subsection and under subsections (a) and (c).

''(J) Such other information as the Secretary shall require.

''(3) EMERGENCIES.—The Secretary shall issue regulations with respect to the waiver of any requirement established under paragraphs (1) and (2) in a case where emergency health care is needed.

''(c) PATIENT'S RIGHT TO REFUSE INFORMATION AND TREATMENT.—The Secretary shall issue regulations requiring each institutional and noninstitutional health care provider receiving payment for services provided under title XVIII or XIX to inform any individual receiving services under such title of such individual's right—

''(1) to refuse any information which is available to such individual under the regulations described in subsections (a) and (b);

''(2) to refuse any procedure or treatment;

''(3) to refuse attendance by any such provider; or

''(4) to leave the premises of any such provider.

''(d) DEFINITIONS.—As used in this section—

''(1) INSTITUTIONAL HEALTH CARE PROVIDER.—The term 'institutional health care provider' means any hospital, clinic, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or other facility receiving payment for services provided under title XVIII or XIX, as determined by the Secretary.

''(2) NONINSTITUTIONAL HEALTH CARE PROVIDER.—The term 'noninstitutional health care provider' means any physician, physician assistant,

nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or other individual receiving payment for services provided under title XVIII or XIX, as determined by the Secretary.

''(e) COMPLIANCE.—

''(1) PENALTIES FOR FAILURE TO COMPLY.—The Secretary shall issue regulations establishing appropriate penalties for any failure to comply with the regulations issued under this section.

''(2) WAIVER OF COMPLIANCE.—The Secretary may waive any of the requirements under the regulations issued under this section if a health care provider demonstrates that such requirements will result in an undue burden on such provider.''.

SEC. 302. OUTREACH ACTIVITIES.

(a) MEDICARE PROGRAM.—

(1) GRANTS TO NONPROFIT PRIVATE ENTITIES FOR OUTREACH ACTIVITIES.—

(A) AUTHORITY.—The Secretary of Health and Human Services (hereafter referred to in this paragraph as the ''Secretary''), is authorized to award grants, on a competitive basis, to nonprofit private entities to enable such entities to develop outreach activities to inform beneficiaries under title XVIII of the Social Security

Act of the information available to such beneficiaries pursuant to regulations issued by the Secretary under section 1144 of the Social Security Act as added by section 311 of this Act.

(B) APPLICATION.—To be eligible to receive a grant under subparagraph (A), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 1994, $5,000,000 for fiscal year 1995, and $5,000,000 for fiscal year 1996.

(2) OUTREACH THROUGH NOTICE OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(A) in paragraph (2), by striking ‘‘, and’’ and inserting a comma,

(B) in paragraph (3), by striking the period and inserting ‘‘, and’’, and

(C) by inserting after paragraph (3), the following new paragraph:

''(4) a description of the information available to beneficiaries under this title pursuant to regulations issued by the Secretary under section 1144.''.

(b) MEDICAID PROGRAM.—

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), is amended—

(A) by striking ''and'' at the end of paragraph (54),

(B) by striking the period at the end of paragraph (58) (as added by section 4751(a)(1)(C) of the Omnibus Budget Reconciliation Act of 1990) and inserting a semicolon,

(C) by redesignating the second paragraph (58) (as added by section 4752(c)(1)(C) of the Omnibus Budget Reconciliation Act of 1990) as paragraph (59) and by striking the period at the end and inserting ''; and'', and

(D) by adding at the end the following new paragraph:

''(60) provide for an outreach program informing individuals who receive medical assistance under this title of the information available to such individ-

uals pursuant to regulations issued by the Secretary under section 1144.''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Paragraph (1) shall apply to calendar quarters beginning on or after January 1, 1994.

(B) GENERAL RULE.—In the case of a State which the Secretary determines requires State legislation (other than legislation authorizing or appropriating funds) in order to comply with paragraph (1), the State shall not be regarded as failing to comply with such paragraph solely on the basis of its failure to meet the requirements of such paragraph before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE IV—PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT

SEC. 401. RIGHT TO DECLINE MEDICAL TREATMENT.

(a) RIGHTS OF COMPETENT ADULTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a State may not restrict the right of a competent adult to consent to, or to decline, medical treatment.

(2) LIMITATIONS.—

(A) AFFECT ON THIRD PARTIES.—A State may impose limitations on the right of a competent adult to decline treatment if such limitations protect third parties (including minor children) from harm.

(B) TREATMENT WHICH IS NOT MEDICALLY INDICATED.—Nothing in this section shall be construed to require that any individual be offered, or that any individual may demand, medical treatment which the health care provider does not have available, or which is futile, or which is otherwise not medically indicated.

(b) RIGHTS OF INCAPACITATED ADULTS.—

(1) IN GENERAL.—Notwithstanding incapacity, each adult has a right to consent to, or to decline, medical treatment. Except as provided in subsection

(a)(2)(A), States may not restrict the right to consent to, or to decline, medical treatment as exercised by an adult through the documents specified in this subsection, or through similar documents or other written methods of directive which clearly and convincingly evidence the adult's treatment choices.

(2) ADVANCE DIRECTIVES AND POWERS OF ATTORNEY.—

(A) IN GENERAL.—In order to facilitate the communication, despite incapacity, of an adult's treatment choices, the Secretary of Health and Human Services (hereafter in this title referred to as the ''Secretary''), in consultation with the Attorney General, shall develop a national advance directive form that—

(i) shall not limit or otherwise restrict, except as provided in subsection (a)(2)(A), an adult's right to consent to, or to decline, medical treatment; and

(ii) shall, at minimum—

(I) provide the means for an adult to declare such adult's own treatment choices in the event of a terminal condition;

(II) provide the means for an adult to declare, at such adult's option, treatment choices in the event of other conditions (such as persistent vegetative state) which are chronic and debilitating, which are medically incurable, and from which such adult likely will not recover; and

(III) provide the means by which an adult may, at such adult's option, declare such adult's wishes with respect to all forms of medical treatment, including forms of medical treatment such as the provision of nutrition and hydration by artificial means which may be, in some circumstances, relatively nonburdensome.

(B) NATIONAL DURABLE POWER OF ATTORNEY FORM.—The Secretary, in consultation with the Attorney General, shall develop a national durable power of attorney form for health care decisionmaking. The form shall provide a means for any adult to designate another adult or adults to exercise the same decisionmaking

powers which would, under State law, otherwise be exercised by next of kin.

(C) HONORED BY ALL HEALTH CARE PROVIDERS.—The national advance directive and durable power of attorney forms developed by the Secretary shall be honored by all health care providers.

(D) LIMITATIONS.—No individual shall be required to execute an advance directive. This title makes no presumption concerning the intention of an individual who has not executed an advance directive. An advance directive shall be sufficient, but not necessary, proof of an adult's treatment choices with respect to the circumstances addressed in the advance directive.

(3) DEFINITION.—For purposes of this subsection, the term ''incapacity'' means the inability to understand the nature and consequences of health care decisions (including the intended benefits and foreseeable risks of, and alternatives to, proposed treatment options), and to reach informed decisions concerning health care. Individuals who are incapacitated include adjudicated incompetents and individuals who have not been adjudicated incompetent but

who, nonetheless, lack the capacity to formulate or communicate decisions concerning health care.

(c) HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—No health care provider may provide treatment to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in subsection (b)(2), or by a similar written advance directive form or another written method of directive which clearly and convincingly evidence the adult's treatment choices. A health provider who acts in good faith pursuant to the preceding sentence shall be immune from criminal or civil liability or discipline for professional misconduct.

(2) HEALTH CARE PROVIDERS UNDER THE MEDICARE AND MEDICAID PROGRAMS.—Any health care provider who knowingly provides services to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in subsection (b)(2), or by a similar written advance directive form or another written method of directive which clearly and convincingly evidence the adult's treatment choices, shall be denied payment for such services under titles XVIII and XIX of the Social Security Act.

(3) TRANSFERS.—Health care providers who object to the provision of medical care in accordance with an adult's wishes shall transfer the adult to the care of another health care provider.

(d) DEFINITION.—For purposes of this section, the term ''adult'' means an individual who is 18 years of age or older.

SEC. 402. FEDERAL RIGHT ENFORCEABLE IN FEDERAL COURTS.

The rights recognized in this title may be enforced by filing a civil action in an appropriate district court of the United States.

SEC. 403. SUICIDE AND HOMICIDE.

Nothing in this title shall be construed to permit, condone, authorize, or approve suicide or mercy killing, or any affirmative act to end a human life.

SEC. 404. RIGHTS GRANTED BY STATES.

Nothing in this title shall impair or supersede rights granted by State law which exceed the rights recognized by this title.

SEC. 405. EFFECT ON OTHER LAWS.

(a) IN GENERAL.—Except as specified in subsection (b), written policies and written information adopted by health care providers pursuant to sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public

Law 101–508), shall be modified within 6 months of enactment of this title to conform to the provisions of this title.

(b) DELAY PERIOD FOR UNIFORM FORMS.—Health care providers shall modify any written forms distributed as written information under sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) not later than 6 months after promulgation of the forms referred to in subparagraphs (A) and (B) of section 401(b)(2) by the Secretary.

SEC. 406. INFORMATION PROVIDED TO CERTAIN INDIVIDUALS.

The Secretary shall provide on a periodic basis written information regarding an individual's right to consent to, or to decline, medical treatment as provided in this title to individual's who are beneficiaries under titles II, XVI, XVIII, and XIX of the Social Security Act.

SEC. 407. RECOMMENDATIONS TO THE CONGRESS ON ISSUES RELATING TO A PATIENT'S RIGHT OF SELF-DETERMINATION.

Not later than 180 days after the date of the enactment of this Act the Secretary shall provide recommendations to the Congress concerning the medical, legal, ethical, social, and educational issues related to this title. In

developing recommendations under this section the Secretary shall address the following issues:

(1) the contents of the forms referred to in subparagraphs (A) and (B) of section 401(b)(2);

(2) issues pertaining to the education and training of health care professionals concerning patients' self-determination rights;

(3) issues pertaining to health care professionals' duties with respect to patients' rights, and health care professionals' roles in identifying, assessing, and presenting for patient consideration medically indicated treatment options; and

(4) such other issues as the Secretary may identify.

SEC. 408. EFFECTIVE DATE.

This title shall take effect on the date that is 6 months after the date of enactment of this Act.

TITLE V—PRIMARY AND PREVENTIVE CARE PROVIDERS

SEC. 501. INCREASING PAYMENTS TO CERTAIN NONPHYSICIAN PROVIDERS UNDER THE MEDICARE PROGRAM.

(a) INCREASE IN PAYMENTS TO NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES, AND PHYSICIAN ASSISTANTS.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (K), by striking ''80 percent'' and all that follows through ''physician)'' and inserting ''97 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician'';

(B) by redesignating subparagraph (M) the second place it appears and subparagraph (N), as subparagraphs (N) and (O), respectively; and

(C) by amending subparagraph (N), as redesignated, to read as follows: ''(N) with respect to services described in section 1861(s)(2)(K) (relating to services provided by a nurse practitioner, clinical nurse specialist, or physician assistant) the amounts paid shall be 97 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician,''.

(2) NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Section 1842(b)(12) of such Act (42 U.S.C. 1395u(b)(12)) is amended to read as follows:

''(12) With respect to services described in clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners)—

''(A) payment under this part may only be made on an assignment-related basis; and

''(B) the prevailing charges determined under paragraph (3) shall not exceed—

''(i) in the case of services performed as an assistant at surgery, 97 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

''(ii) in other cases, 97 percent of the fee schedule amount specified in section 1848 for such services performed by physicians who are not specialists.''.

(3) DIRECT PAYMENT FOR ALL NURSE PRACTITIONERS OR CLINICAL NURSE SPECIALISTS.—Section 1832(a)(2)(B)(iv) of such Act (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))''.

(4) REMOVAL OF RESTRICTIONS ON SETTINGS.—Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is amended—

(A) in clause (i), by striking ''(I) in a hospital'' and all that follows through ''professional shortage area,'';

(B) in clause (ii), by striking ''in a skilled'' and all that follows through ''1919(a)''; and

(C) in clause (iii), by striking ''in a rural'' and all that follows through ''(d)(2)(D))''.

(b) BONUS PAYMENT FOR SERVICES PROVIDED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)) is amended—

(1) by inserting ''(1)'' after ''(m)''; and

(2) by adding at the end the following new paragraph:

''(2) In the case of services of a nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife, or certified registered nurse anesthetist furnished to an individual described in paragraph (1) in an area that is a health professional shortage area as described in such paragraph, in addition to the amount otherwise paid under this part, there shall also be paid to such service provider (or to an employer in the cases described in subparagraph (C) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Trust Fund an amount equal to 10 per-

cent of the payment amount for such services under this part.''.

SEC. 502. REQUIRING COVERAGE OF CERTAIN NONPHYSICIAN PROVIDERS UNDER THE MEDICAID PROGRAM.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(1) in paragraph (21), by striking ''; and'' and inserting a semicolon;

(2) in paragraph (24), by striking the period at the end and inserting a semicolon;

(3) by redesignating paragraphs (22), (23), and (24) as paragraphs (25), (22), and (23), respectively;

(4) by inserting after paragraph (23) the following new paragraph:

''(24) services furnished by a physician assistant, nurse practitioner, clinical nurse specialist (as defined in section 1861(aa)(5)), and certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and'';

(5) by striking the semicolon at the end of paragraph (25), as redesignated, and inserting a period; and

(6) by transferring and inserting paragraph (25), as redesignated, after paragraph (24).

SEC. 503. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.

Part C of title VII of the Public Health Service Act is amended by adding at the end thereof the following new section:

"SEC. 753. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible schools of medicine or osteopathic medicine to enable such schools to provide medical students for tutorial programs or as participants in clinics designed to interest high school or college students in careers in general medical practice.

''(b) APPLICATION.—To be eligible to receive a grant under this section, a school of medicine or osteopathic medicine shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the school will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be used to—

''(A) fund programs under which students of the grantee are provided as tutors for high school and college students in the areas of math, science, health promotion and prevention, first aide, nutrition and prenatal care;

''(B) fund programs under which students of the grantee are provided as participants in clinics and seminars in the areas described in paragraph (1); and

''(C) conduct summer institutes for high school and college students to promote careers in medicine.

''(2) DESIGN OF PROGRAMS.—The programs, institutes and other activities conducted by grantees under paragraph (1) shall be designed to—

''(A) give medical students desiring to practice general medicine access to the local community;

''(B) provide information to high school and college students concerning medical school and the general practice of medicine; and

''(C) promote careers in general medicine.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section,

$5,000,000 for fiscal year 1994, and such sums as may be necessary for fiscal year 1995.''.

SEC. 504. GENERAL MEDICAL PRACTICE GRANTS.

Part C of title VII of the Public Health Service Act (as amended by section 503) is further amended by adding at the end thereof the following new section:

''SEC. 754. GENERAL MEDICAL PRACTICE GRANTS.

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible public or private nonprofit schools of medicine or osteopathic medicine, hospitals, residency programs in family medicine or pediatrics, or to a consortium of such entities, to enable such entities to develop effective strategies for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(b) APPLICATION.—To be eligible to receive a grant under this section, an entity of the type described in subsection (a) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the entity will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—Amounts received under a grant awarded under this section shall be used to fund

programs under which effective strategies are developed and implemented for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $25,000,000 for each of the fiscal years 1994 through 1998, and such sums as may be necessary for fiscal years thereafter.''.

SEC. 505. PAYMENTS FOR DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION COSTS.

(a) DIRECT MEDICAL EDUCATION COSTS.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (1)—

(A) by striking ''hospitals for direct medical education costs'' and inserting ''hospitals and public and private nonprofit entities with approved medical residency training programs for direct medical education costs''; and

(B) by striking ''hospitals associated'' and inserting ''hospitals and public and private nonprofit entities with approved medical residency training programs associated'';

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A) by striking ''each hospital'' and inserting ''each hospital or public or private nonprofit entity'';

(B) in subparagraph (A)—

(i) in the heading, by striking ''HOSPITAL'S '';

(ii) by striking ''the hospital's'' and inserting ''the hospital's or entity's''; and

(iii) by striking ''the hospital'' and inserting ''the hospital or entity'';

(C) in clause (ii) of subparagraph (B), by striking ''a hospital if the hospital's'' and inserting ''a hospital or entity if the hospital's or entity's'';

(D) in subparagraph (C), by striking ''the hospital'' each place it appears and inserting ''the hospital or the entity'';

(E) in subparagraph (D), by striking ''the hospital'' and inserting ''the hospital or the entity''; and

(F) in subparagraph (E), by striking ''a hospital'' and inserting ''a hospital or entity'';

(3) in paragraph (3)—

(A) in the heading, by striking ''HOSPITAL'';

(B) in subparagraph (A),

(i) in the matter preceding clause (i), by striking ''hospital cost reporting period'' and inserting ''cost reporting period of a hospital or a public or private nonprofit entity''; and

(ii) in clause (ii), by striking ''the hospital's'' and inserting ''the hospital's or entity's'';

(C) in subparagraph (B),

(i) in the matter preceding clause (i), by striking ''hospital cost reporting period'' and inserting ''cost reporting period of a hospital or a public or private nonprofit entity''; and

(ii) in clauses (i) and (ii), by striking ''hospital's'' each place it appears and inserting ''hospital's or entity's''; and

(D) in subparagraph (C), by striking ''hospital's cost reporting period'' and inserting ''cost reporting period of a hospital or a public or private nonprofit entity''; and

(4) in paragraph (4)—

(A) in subparagraph (B), by striking ''hospital'' each place it appears and inserting ''hospital or public or private nonprofit entity''; and

(B) in subparagraph (E), by striking ''hospital'' and inserting ''hospital or public or private nonprofit entity''.

(b) INDIRECT MEDICAL EDUCATION COSTS.—

(1) IN GENERAL.—Section 1848 of such Act (42 U.S.C. 1395w–4) is amended—

(A) by redesignating subsection (j) as subsection (k); and

(B) by inserting after subsection (i) the following new subsection:

''(j) PAYMENTS FOR INDIRECT GRADUATE MEDICAL EDUCATION COSTS.—

''(1) IN GENERAL.—The Secretary shall provide for an additional payment for indirect costs of medical education in an amount equal to the product of—

''(A) the amount determined under subsection (a)(1) for qualified physician's services (as defined in paragraph (2)), and

''(B) the indirect teaching adjustment factor determined in accordance with section 1886(d)(5)(B)(ii) with 'r' equal to .2.

''(2) QUALIFIED PHYSICIAN'S SERVICES.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'qualified physician's services' means physician's services (as defined in subsection (k)(3)) that are—

''(i) provided during the course of clinical training by medical residents in the initial 3 years of postgraduate medical training in approved medical residency training programs in the fields of family medicine (as defined by the Secretary), general internal medicine (as defined by the Secretary), and general pediatrics (as defined by the Secretary), and

''(ii) provided at clinical training sites affiliated with approved medical residency training programs in family medicine, general internal medicine, and general pediatrics.

''(B) CERTAIN SERVICES EXCLUDED.—For purposes of paragraph (1), the term 'qualified physician's services' shall not include services provided during an inpatient hospital stay for which payment is made under part A of this title.''.

(2) CONFORMING AMENDMENTS.—Section 1848 of such Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (a)(1), by striking ''subsection (j)(3)'' and inserting ''subsection (k)(3)'';

(B) in subsection (b)(1), by striking ''subsection (j)(2)'' and inserting ''(k)(2)''; and

(C) in subparagraphs (C) and (D) of subsection (d)(2), by striking ''subsection (j)(1)'' and inserting ''subsection (k)(1)''.

(c) SUBSECTION (d) HOSPITALS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(v) In determining such adjustment the Secretary shall count only those interns and residents who are in the initial 3 years of postgraduate medical training.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective for cost reporting periods beginning on or after October 1, 1993.

TITLE VI—MEDICARE PREFERRED PROVIDER DEMONSTRATION PROJECTS

SEC. 601. ESTABLISHMENT OF MEDICARE PRIMARY AND SPECIALTY PREFERRED PROVIDER ORGANIZATION DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act the Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'') shall provide for up to 10 demonstration projects to test the effectiveness of providing payment under the medicare program under title XVIII of the Social Security Act for primary and specialty procedures and services (as determined appropriate by the Secretary) furnished by preferred provider organizations. The demonstration projects provided for under this section by the Secretary shall—

(1) test the cost-effectiveness of preferred provider organizations furnishing primary and specialty services in controlling the volume of such services performed or ordered by physicians, and nonphysician providers such as nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, and physician

assistants, for which payment is made under title XVIII of the Social Security Act;

(2) gather information on factors which may encourage medicare beneficiaries to participate in a preferred provider organizational network;

(3) examine the efficacy of permanently establishing managed care networks of primary and specialty service providers; and

(4) examine the factors necessary to increase the quality and efficiency of primary and specialty services furnished by preferred provider networks in order to realize increased savings under the medicare program and to increase medicare beneficiary participation in such networks.

(b) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary may waive such requirements of title XVIII of the Social Security Act as the Secretary determines necessary in conducting demonstration programs under this section, including—

(1) coinsurance requirements;

(2) provider payment arrangements;

(3) beneficiary deductibles; and

(4) reimbursement for nonphysician providers.

(c) DURATION OF PROJECTS.—The demonstration projects provided for under this section shall be conducted

for a period not to exceed 3 years from the date of the enactment of this Act.

(d) REPORT.—Not later than 180 days after the date of expiration of the demonstration projects conducted under this section the Secretary shall report to the Congress on the results of the demonstration projects including recommendations for modifications in the medicare program to increase the utilization of preferred provider organizations in providing primary and specialty services under such program.

TITLE VII—COST CONTAINMENT

SEC. 701. NEW DRUG CLINICAL TRIALS PROGRAM.

Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following new section:

"SEC. 409A. NEW DRUG CLINICAL TRIALS PROGRAM.

''(a) IN GENERAL.—The Director of the National Institutes of Health (hereafter referred to in this section as the 'Director') is authorized to establish and implement a program for the conduct of clinical trials with respect to new drugs and disease treatments determined to be promising by the Director. In determining the drugs and disease treatments that are to be the subject of such clinical trials, the Director shall give priority to those drugs

and disease treatments targeted toward the diseases determined—

''(1) to be the most costly to treat;

''(2) to have the highest mortality; or

''(3) to affect the greatest number of individuals.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $120,000,000 for fiscal year 1994, and such sums as may be necessary in each of the fiscal years 1995 through 1998.''.

SEC. 702. MEDICAL TREATMENT EFFECTIVENESS.

(a) RESEARCH ON COST-EFFECTIVE METHODS OF HEALTH CARE.—Section 926 of the Public Health Service Act (42 U.S.C. 299c–5) is amended—

(1) in subsection (a), by striking ''and $115,000,000 for fiscal year 1993'' and inserting ''$115,000,000 for fiscal year 1993, and such sums as may be necessary for each of the fiscal years 1994 through 1997''; and

(2) by adding at the end the following new subsection:

''(f) USE OF ADDITIONAL APPROPRIATIONS.—Within amounts appropriated under subsection (a) for each of the fiscal years 1993 through 1996 that are in excess of the

amounts appropriated under such subsection for fiscal year 1992, the Secretary shall give priority to expanding research conducted to determine the most cost-effective methods of health care and for developing and disseminating new practice guidelines related to such methods. In utilizing such amounts, the Secretary shall give priority to diseases and disorders that the Secretary determines are the most costly to the United States and evidence a wide variation in current medical practice.''.

(b) RESEARCH ON MEDICAL TREATMENT OUTCOMES.—

(1) IMPOSITION OF TAX ON HEALTH INSURANCE POLICIES.—

(A) IN GENERAL.—Chapter 36 of the Internal Revenue Code of 1986 (relating to certain other excise taxes) is amended by adding at the end thereof the following new subchapter:

''Subchapter G—Tax on Health Insurance Policies

''SEC. 4501. IMPOSITION OF TAX.

''(a) GENERAL RULE.—There is hereby imposed a tax equal to .001 cent on each dollar, or fractional part thereof, of the premium paid on a policy of health insurance.

''(b) DEFINITION.—For purposes of subsection (a), the term 'policy of health insurance' means any policy or other instrument by whatever name called whereby a contract of insurance is made, continued, or renewed with respect to the health of an individual or group of individuals.

"SEC. 4502. LIABILITY FOR TAX.

''The tax imposed by this subchapter shall be paid, on the basis of a return, by any person who makes, signs, issues, or sells any of the documents and instruments subject to the tax, or for whose use or benefit the same are made, signed, issued or sold. The United States or any agency or instrumentality thereof shall not be liable for the tax.''.

(B) CONFORMING AMENDMENT.—The table of subchapters for chapter 36 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

''SUBCHAPTER G. Tax on health insurance policies.''.

(2) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of such Code (relating to trust fund code) is amended by adding at the end thereof the following new section:

''SEC. 9512. TRUST FUND FOR MEDICAL TREATMENT OUTCOMES RESEARCH.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Trust Fund for Medical Treatment Outcomes Research' (hereafter referred to in this section as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO TRUST FUND.—There is hereby appropriated to the Trust Fund an amount equivalent to the taxes received in the Treasury under section 4501 (relating to tax on health insurance policies).

''(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—On an annual basis the Secretary shall distribute the amounts in the Trust Fund to the Secretary of Health and Human Services. Such amounts shall be available to the Secretary of Health and Human Services to pay for research activities related to medical treatment outcomes.''.

(B) CONFORMING AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end thereof the following new item:

''Sec. 9512. Trust Fund for Medical Treatment Outcomes Research.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to policies issued after December 31, 1993.

SEC. 703. HEALTH CARE COST CONTROL—EXPENDITURE TARGETS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary''), after considering the recommendations of the Health Care Cost Control Advisory Committee established under subsection (b), shall prepare and submit to the appropriate committees of the Congress a report concerning the establishment of national spending targets for health care and health care services. Such report shall contain the recommendations of the Secretary concerning the feasibility—

(1) for controlling the cost of health care, reducing cost shifting and maintaining the quality of care;

(2) of establishing national targets for health expenditures;

(3) of establishing national reimbursement targets for hospital services;

(4) of establishing national reimbursement targets for physicians' services; and

(5) of establishing national reimbursement targets for prescription drug services.

(b) HEALTH CARE COST CONTROL ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—There shall be established a Health Care Cost Control Advisory Committee (hereafter referred to in this subsection as the ''Committee'').

(2) MEMBERSHIP.—The Committee shall be composed of 8 individuals appointed by the Secretary, representing—

(A) physicians;

(B) hospitals;

(C) pharmacies;

(D) private insurers;

(E) State and local governments;

(F) employers;

(G) organized labor; and

(H) academia with expertise as a health economist.

(3) COMPENSATION.—

(A) IN GENERAL.—Members of the Committee shall serve without compensation.

(B) EXPENSES REIMBURSED.—While away from their homes or regular places of business

on the business of the Committee, the members of the Committee may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons employed intermittently in Government service.

(C) APPLICATION OF THE ACT.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply with respect to the Committee.

(D) SUPPORT.—The Secretary shall supply such necessary office facilities, office supplies, support services, and related expenses as necessary to carry out the functions of the Committee.

TITLE VIII—LONG-TERM CARE

Subtitle A—Tax Treatment of Qualified Long-Term Care Insurance Policies

SEC. 801. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a

section or other provision of the Internal Revenue Code of 1986.

SEC. 802. DEFINITIONS OF QUALIFIED LONG-TERM CARE INSURANCE AND PREMIUMS.

(a) IN GENERAL.—Chapter 79 (relating to definitions) is amended by adding at the end the following new section:

"SEC. 7705. QUALIFIED LONG-TERM CARE INSURANCE AND PREMIUMS.

''(a) QUALIFIED LONG-TERM CARE INSURANCE.—

''(1) IN GENERAL.—For purposes of this title, the term 'qualified long-term care insurance' means insurance under a policy or rider, issued by a qualified issuer, which—

''(A) provides coverage for not less than 12 consecutive months for each covered person,

''(B) provides benefits on an expense incurred, indemnity, disability, prepaid, capitation, or other basis,

''(C) provides benefits for—

''(i) medically necessary diagnostic, preventive, therapeutic, rehabilitation, or maintenance services,

''(ii) personal care services necessitated by physical disability, or

''(iii) preventive, therapeutic, rehabilitation, maintenance, or personal care services necessitated by cognitive impairment or the loss of functional capacity,

when provided in a nursing home, a respite care facility, the home of the covered individual, or any other setting which is not an acute care unit of a hospital or a medical clinic, and

''(D) provides coverage for care described in subparagraph (C) (other than nursing home care) equal to not less than 47.5 percent of the national median cost of nursing care coverage, as determined by the Secretary.

''(2) QUALIFIED ISSUER.—For purposes of paragraph (1), the term 'qualified issuer' means any of the following, if subject to the jurisdiction and regulation of at least 1 State insurance department:

''(A) Private insurance company.

''(B) Fraternal benefit society.

''(C) Nonprofit health corporation.

''(D) Nonprofit hospital corporation.

''(E) Nonprofit medical service corporation.

''(F) Prepaid health plan.

''(b) QUALIFIED LONG-TERM CARE PREMIUMS.—

''(1) IN GENERAL.—For purposes of this title, the term 'qualified long-term care premiums' means the amount paid during a taxable year for qualified long-term care insurance covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

''(2) INDEXING.—

''(A) IN GENERAL.—In the case of any taxable year beginning after December 31, 1993, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment for such taxable year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(B) MEDICAL CARE COST ADJUSTMENT.—For purposes of subparagraph (A), the medical care cost adjustment for any taxable year is the percentage (if any) by which—

''(i) the medical care component of the Consumer Price Index (as defined in

section 1(f)(5)) for August of the calendar year preceding the calendar year in which the taxable year begins, exceeds

''(ii) such component for August of 1992.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7704 the following new item:

''Sec. 7705. Qualified long-term care insurance and premiums.''.

SEC. 803. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF TAXATION OF INSURANCE COMPANIES.

(a) IN GENERAL.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT OR HEALTH INSURANCE.—For purposes of this subchapter, any reference to noncancellable accident or health insurance contracts shall be treated as including a reference to qualified long-term care insurance.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 804. TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) EXCLUSION OF AMOUNTS RECEIVED.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid to an individual under a life insurance contract on the life of an insured who is a terminally ill individual, who has a dread disease, or who has been permanently confined to a nursing home shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less.

''(3) DREAD DISEASE.—For purposes of this subsection, the term 'dread disease' means a medical condition which has required or requires extraordinary medical intervention without which the insured would die, or a medical condition which would,

in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span.

''(4) PERMANENTLY CONFINED TO A NURSING HOME.—For purposes of this subsection, an individual has been permanently confined to a nursing home if the individual is presently confined to a nursing home and has been certified by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in the individual remaining in a nursing home for the rest of the individual's life.''.

(b) TREATMENT OF QUALIFIED ACCELERATED DEATH BENEFIT RIDERS AS LIFE INSURANCE.—

(1) IN GENERAL.—Section 818 (relating to other definitions and special rules), as amended by section 803, is amended by adding at the end the following new subsection:

''(h) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDER.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider or addendum on, or other provision of, a life insurance contract which provides for payments to an individual on the life of an insured upon such insured becoming a terminally ill individual (as defined in section 101(g)(2)), incurring a dread disease (as defined in section 101(g)(3)), or being permanently confined to a nursing home (as defined in section 101(g)(4)).''.

(2) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(A) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Subparagraph (A) of section 7702(f)(5) (relating to definition of life insurance contract) is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(h)(2)), or any qualified long-term care insurance which reduces the death benefit, or''.

(B) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Revenue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a rider or addendum on, or other provision of, a life insurance contract permitting the acceleration of death benefits (as described in section 101(g)) or for qualified long-term care insurance shall not be treated as a modification or material change of such contract.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

Subtitle B—Tax Incentives for Purchase of Qualified Long-Term Care Insurance

SEC. 811. CREDIT FOR QUALIFIED LONG-TERM CARE PREMIUMS.

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

"SEC. 35. LONG-TERM CARE INSURANCE CREDIT.

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the qualified long-term care premiums (as defined in section 7705(b)) paid during such taxable year for such individual or the spouse of such individual.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of this section, the term 'applicable percentage' means 28 percent reduced (but not below zero) by 1 percentage point for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the base amount.

''(2) BASE AMOUNT.—For purposes of paragraph (1) the term 'base amount' means—

''(A) except as otherwise provided in this paragraph, $25,000,

''(B) $40,000 in the case of a joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year (within the meaning of section 7703) but does not file a joint return for such taxable year, and

''(ii) does not live apart from his or her spouse at all times during the taxable year.

''(c) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount allowed as a credit under this section shall not be taken into account under section 213.''.

(b) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 is amended by striking the item relating to section 35 and inserting the following:

''Sec. 35. Long-term care insurance credit.
''Sec. 36. Overpayments of tax.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 812. DEDUCTION FOR EXPENSES RELATING TO QUALIFIED LONG-TERM CARE.

(a) DEDUCTION FOR QUALIFIED LONG-TERM CARE PREMIUMS.—Subparagraph (C) of section 213(d)(1) (relating to the definition of medical care) is amended by striking ''aged)'' and inserting the following: ''aged, and amounts paid as qualified long-term care premiums (as defined in section 7705(b))''.

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 (relating

to deduction for medical expenses) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has long-term care expenses described in section 7705(a)(1)(C), but only to the extent of such expenses.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 813. EXCLUSION FROM GROSS INCOME OF BENEFITS RECEIVED UNDER QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(j) SPECIAL RULES RELATING TO QUALIFIED LONG-TERM CARE INSURANCE.—For purposes of section 104, this section, and section 106—

''(1) BENEFITS TREATED AS PAYABLE FOR SICKNESS, ETC.—Any benefit received through qualified long-term care insurance shall be treated as amounts received through accident or health insurance for personal injuries or sickness.

''(2) EXPENSES FOR WHICH REIMBURSEMENT PROVIDED UNDER QUALIFIED LONG-TERM CARE INSURANCE TREATED AS INCURRED FOR MEDICAL CARE OR FUNCTIONAL LOSS.—

''(A) EXPENSES.—Expenses incurred by the taxpayer or spouse, or by the dependent, parent, or grandparent of either, to the extent of benefits paid under qualified long-term care insurance shall be treated for purposes of subsection (b) as incurred for medical care (as defined in section 213(d)).

''(B) BENEFITS.—Benefits received under qualified long-term care insurance shall be treated for purposes of subsection (c) as payment for the permanent loss or loss of use of a member or function of the body or the permanent disfigurement of the taxpayer or spouse, or the dependent, parent, or grandparent of either.

''(3) REFERENCES TO ACCIDENT AND HEALTH PLANS.—

''(A) IN GENERAL.—Any reference to an accident or health plan shall be treated as including a reference to a plan providing qualified long-term care insurance.

''(B) LIMITATION.—Subparagraph (A) shall apply for purposes of section 106 only to the extent of qualified long-term care premiums (as defined in section 7705(b)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 814. EMPLOYER DEDUCTION FOR CONTRIBUTIONS MADE FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Subparagraph (B) of section 404(b)(2) (relating to plans providing certain deferred benefits) is amended to read as follows:

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply to—

''(i) any benefit provided through a welfare benefit fund (as defined in section 419(e)), or

''(ii) any benefit provided under qualified long-term care insurance through the payment (in whole or in part) of qualified long-term care premiums (as defined in section 7705(b)) by an employer pursuant to a plan for its active or retired employees, but only if any refund or premium is

applied to reduce the future costs of the plan or increase benefits under the plan.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 815. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE IN CAFETERIA PLANS.

(a) IN GENERAL.—Paragraph (2) of section 125(d) (relating to the exclusion of deferred compensation) is amended by adding at the end the following new subparagraph:

''(D) EXCEPTION FOR LONG-TERM CARE INSURANCE CONTRACTS.—For purposes of subparagraph (A), amounts paid or incurred for any long-term care insurance contract shall not be treated as deferred compensation to the extent section 404(b)(2)(A) does not apply to such amounts by reason of section 404(b)(2)(B)(ii).''.

(b) CONFORMING AMENDMENT.—Subsection (f) of section 125 (relating to qualified benefits) is amended by striking ''and such term includes'' and inserting the following: '', qualified long-term care insurance, and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 816. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS AND SECTION 401(k) PLANS FOR QUALIFIED LONG-TERM CARE PREMIUMS AND EXPENSES.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by inserting after section 135 the following new section:

"SEC. 136. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT PLANS AND SECTION 401(k) PLANS FOR QUALIFIED LONG-TERM CARE PREMIUMS AND EXPENSES.

''(a) GENERAL RULE.—In the case of an individual, gross income shall not include any qualified distribution.

''(b) QUALIFIED DISTRIBUTION.—For purposes of this section, the term 'qualified distribution' means any amount distributed from an individual retirement plan or a section 401(k) plan during the taxable year if such amount is used during such year—

''(1) to pay qualified long-term care premiums (as defined in section 7705(b)) for the benefit of the payee or distributee or the spouse of the payee or distributee, if such policy may not be surrendered for cash, or

''(2) to pay long-term care expenses (as described in section 7705(a)(1)(C)) of such an individual.

''(c) SPECIAL RULES.—For purposes of this section—

''(1) QUALIFIED DISTRIBUTIONS FROM IRA DEEMED MADE FIRST FROM DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS.—For purposes of section 72, qualified distributions from an individual retirement plan shall be treated as made from designated nondeductible contributions to the extent thereof and then from other amounts.

''(2) SPECIAL RULES FOR SECTION 401(k) PLANS.—

''(A) QUALIFIED DISTRIBUTIONS FROM SECTION 401(k) PLAN MAY NOT EXCEED ELECTIVE DEFERRALS.—This section shall not apply to any distribution from a section 401(k) plan to the extent the aggregate amount of such distributions for the use described in subsection

(a) exceeds the aggregate employer contributions made pursuant to the employee's election under section 401(k)(2) (and the income thereon).

''(B) WITHDRAWALS NOT TO CAUSE DISQUALIFICATION.—A plan shall not be treated as failing to satisfy the requirements of section 401, and an arrangement shall not be treated as failing to be a qualified cash or deferred arrangement (as defined in section 401(k)(2)), merely because under the plan or arrangement distributions are permitted which are excludable from gross income by reason of this section.

''(d) SECTION 401(k) PLAN.—For purposes of this section, the term 'section 401(k) plan' means any employer plan which meets the requirements of section 401(a) and which includes a qualified cash or deferred arrangement (as defined in section 401(k)).''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (k) of section 401 is amended by adding at the end the following new paragraph:

''(11) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals for qualified long-term care premiums and expenses, see section 136.".

(2) Subsection (d) of section 408 is amended by adding at the end the following new paragraph:

''(8) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals for qualified long-term care premiums and expenses, see section 136.".

(3) The table of sections for such part III is amended by striking the item relating to section 136 and inserting the following new items:

''Sec. 136. Distributions from individual retirement plans and section 401(k) plans for qualified long-term care premiums and expenses.
''Sec. 137. Cross references to other Acts.''.

(c) INCREASE IN AMOUNT OF DEDUCTIBLE CONTRIBUTIONS TO INDIVIDUAL RETIREMENT PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 219(b)(1) (relating to maximum amount of deduction) is amended by striking ''$2,000'' and inserting ''$4,000''.

(2) SPOUSAL IRA.—Paragraph (2) of section 219(c) (relating to special rules for certain married individuals) is amended by striking ''$2,250'' and ''$2,000'' and inserting ''$4,500'' and ''$4,000'', respectively.

(3) CONFORMING AMENDMENTS.—

(A) Section 408(a)(1) is amended by striking ''in excess of $2,000 on behalf of any individual'' and inserting ''on behalf of any individual in excess of the amount in effect for such taxable year under section 219(b)(1)(A)''.

(B) Section 408(b)(2)(B) is amended by striking ''$2,000'' and inserting ''the dollar amount in effect under section 219(b)(1)(A)''.

(C) Section 408(j) is amended by striking ''$2,000''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 817. EXCLUSION FROM GROSS INCOME FOR AMOUNTS RECEIVED ON CANCELLATION OF LIFE INSURANCE POLICIES AND USED FOR QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—

(1) EXCLUSION FROM GROSS INCOME.—

(A) IN GENERAL.—Part III of subchapter B of chapter 1 (relating to items specifically excluded from gross income), as amended by section 216, is further amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. AMOUNTS RECEIVED ON CANCELLATION, ETC. OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

''No amount (which but for this section would be includible in the gross income of an individual) shall be included in gross income on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the taxable year if—

''(1) such individual has attained age 59½ on or before the date of the transaction, and

''(2) the amount otherwise includible in gross income is used during such year to pay for any policy of qualified long-term care insurance which—

''(A) is for the benefit of such individual or the spouse of such individual if such spouse has attained age 59½ on or before the date of the transaction, and

''(B) may not be surrendered for cash.''.

(B) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 137. Amounts received on cancellation, etc. of life insurance contracts and used to pay premiums for qualified long-term care insurance.
''Sec. 138. Cross references to other Acts.''.

(2) CERTAIN EXCHANGES NOT TAXABLE.—Subsection (a) of section 1035 (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end the following new paragraph:

''(4) in the case of an individual who has attained age 59½, a contract of life insurance or an endowment or annuity contract for a policy of qualified long-term care insurance, if such policy may not be surrendered for cash.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

SEC. 818. USE OF GAIN FROM SALE OF PRINCIPAL RESIDENCE FOR PURCHASE OF QUALIFIED LONG-TERM HEALTH CARE INSURANCE.

(a) IN GENERAL.—Subsection (d) of section 121 (relating to 1-time exclusion of gain from sale of principal residence by individual who has attained age 55) is amended by adding at the end the following new paragraph:

''(10) ELIGIBILITY OF HOME EQUITY CONVERSION SALE-LEASEBACK TRANSACTION FOR EXCLUSION.—

''(A) IN GENERAL.—For purposes of this section, the term 'sale or exchange' includes a home equity conversion sale-leaseback transaction.

''(B) HOME EQUITY CONVERSION SALE-LEASEBACK TRANSACTION.—For purposes of subparagraph (A), the term 'home equity conversion sale-leaseback' means a transaction in which—

''(i) the seller-lessee—

''(I) has attained the age of 55 before the date of the transaction,

''(II) sells property which during the 5-year period ending on the date of the transaction has been owned and used as a principal residence by such seller-lessee for periods aggregating 3 years or more,

''(III) uses a portion of the proceeds from such sale to purchase a policy of qualified long-term care insurance, which policy may not be surrendered for cash,

''(IV) obtains occupancy rights in such property pursuant to a written lease requiring a fair rental, and

''(V) receives no option to repurchase the property at a price less than the fair market price of the property unencumbered by any leaseback at the time such option is exercised, and

''(ii) the purchaser-lessor—

''(I) is a person,

''(II) is contractually responsible for the risks and burdens of ownership and receives the benefits of ownership (other than the seller-lessee's occupancy rights) after the date of such transaction, and

''(III) pays a purchase price for the property that is not less than the fair market price of such property encumbered by a leaseback, and taking into account the terms of the lease.

''(C) ADDITIONAL DEFINITIONS.—For purposes of subparagraph (B)—

''(i) OCCUPANCY RIGHTS.—The term 'occupancy rights' means the right to oc-

cupy the property for any period of time, including a period of time measured by the life of the seller-lessee on the date of the sale-leaseback transaction (or the life of the surviving seller-lessee, in the case of jointly held occupancy rights), or a periodic term subject to a continuing right of renewal by the seller-lessee (or by the surviving seller-lessee, in the case of jointly held occupancy rights).

''(ii) FAIR RENTAL.—The term 'fair rental' means a rental for any subsequent year which equals or exceeds the rental for the first year of a sale-leaseback transaction.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to sales after December 31, 1992, in taxable years beginning after such date.

Subtitle C—Medicaid Amendments

SEC. 821. EXPANSION OF MEDICAID ELIGIBILITY FOR LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new section:

''ELIGIBILITY FOR LONG-TERM CARE BENEFITS

''SEC. 1931. (a) ELIGIBILITY FOR NURSING FACILITY SERVICES.—Any individual—

''(1) who is 65 years of age or older,

''(2) who has resources (including resources of the individual's spouse) which do not exceed the resource limitation specified in subsection (c)(1),

''(3) who is not otherwise eligible for medical assistance for nursing facility services under this title, and

''(4) who has been provided 30 months of nursing facility services (during a period in which the individual required the level of care provided in a nursing facility) during the previous 48 months (or, with respect to the application of subsection (e), 72 months),

is eligible, notwithstanding any other provisions of this title, for medical assistance under this title for nursing facility services so long as the individual continues to meet the requirements of this subsection (other than paragraph (4)) and is confined to a nursing facility or otherwise requires the same level of care as is provided in a nursing facility.

''(b) ELIGIBILITY FOR HOME AND COMMUNITY-BASED CARE.—Any individual—

''(1) who is 65 years of age or older,

''(2) who has resources (including resources of the individual's spouse) which do not exceed the resource limitation specified in subsection (c)(1), and

''(3) who is not otherwise eligible for medical assistance for home and community-based long-term care under this title,

is eligible, notwithstanding any other provisions of this title, for medical assistance under this title for home and community-based long-term care so long as the individual continues to meet the requirements of this subsection and requires the same level of care as is provided in a nursing facility.

''(c) RESOURCE LIMITATION.—

''(1) IN GENERAL.—For purposes of this section, the resource limitation specified in this subsection is $500,000, increased, for each year after 1993, by the percentage increase in the Consumer Price Index for All Urban Consumers (all items; U.S. city average) from July 1992 to July of the previous year, rounded (if not a multiple of $1,000) to the nearest $1,000.

''(2) CERTAIN PERSONAL PROPERTY NOT INCLUDED.—Personal property items with a fair market value less than $5,000 in the aggregate shall not

be included in any calculation of resources under subsections (a) and (b) which are subject to the resource limitation specified in paragraph (1).

''(d) TREATMENT OF LEVEL OF CARE.—

''(1) IN GENERAL.—For purposes of subsections (a) and (b), an individual is considered to require the level of care provided in a nursing facility if the individual cannot perform (without substantial human assistance) at least 3 activities of daily living or needs substantial human assistance because of cognitive or other mental impairment (including Alzheimer's disease).

''(2) ACTIVITIES OF DAILY LIVING DEFINED.—The 'activities of daily living' referred to in paragraph (1) are the following: eating, bathing, dressing, toileting, and transferring in and out of a bed or in and out of a chair.

''(e) SUBSTITUTION OF EXPENSES INCURRED FOR QUALIFIED HOME CARE FOR MONTHS IN NURSING FACILITY.—

''(1) IN GENERAL.—In determining whether an individual has been provided 30 months of nursing facility services under subsection (a)(4), expenses incurred (whether paid for by insurance, themselves, or relatives but not including expenses for which

payment is made under this title, by the Department of Veterans Affairs, the Department of Defense, or other Federal programs) for qualified home care (as defined in paragraph (3)) shall be taken into account in the manner specified in paragraph (2).

''(2) CONVERTING EXPENSES TO MONTHS.—Expenses described in paragraph (1) shall be converted to months of nursing facility services by dividing such expenses by the national median monthly cost (as determined by the Secretary, and using a weighted average for both public and private nursing facilities) for nursing facility services in the month in which the expenses are incurred.

''(3) QUALIFIED HOME CARE DEFINED.—In this subsection, the term 'qualified home care' means home and community-based services described in section 1915(d).''.

(b) CONFORMING AMENDMENTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 302, is further amended—

(1) in paragraph (10)—

(A) in clause (i) of subparagraph (A), by striking ''or'' at the end of subclause (VI), by striking the semicolon at the end of subclause

(VII) and inserting ‘‘, or’’, and by adding at the end the following:

‘‘(VIII) who are described in subsections (a) and (b) of section 1931;’’; and

(B) in the matter following subparagraph (F)—

(i) by striking ‘‘; and (XI)’’; and inserting ‘‘, (XI);

(ii) by striking ‘‘, and (XI)’’ and inserting ‘‘, (XII); and

(iii) by inserting before the semicolon at the end the following: ‘‘, and (XIII) the making available of medical assistance for certain nursing facility services and home and community-based long-term care in accordance with section 1931 shall not, by reason of this paragraph, require such assistance to be made available to other individuals’’;

(2) in paragraph (59), by striking ‘‘; and’’ and inserting a semicolon,

(3) in paragraph (60), by striking the period at the end and inserting ‘‘; and’’, and

(4) by adding at the end the following new paragraph:

''(61) provides for medical assistance for certain nursing facility services and home and community-based long-term care in accordance with section 1931.''.

SEC. 822. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle apply (except as provided under subsection (b)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after 1 year after the date of the enactment of this Act, without regard to whether regulations to implement such amendments are promulgated by such date.

(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter

beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(c) TRANSITION.—In applying the amendments made by this subtitle, only months beginning after the date of the enactment of this Act may be counted toward meeting the 30-month deductible described in section 1931(a)(4) of the Social Security Act, as added by this subtitle.

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